

CLINICAL SITE APPROVAL REQUEST FOR NURSE AIDE I TRAINING PROGRAM

NORTH CAROLINA DIVISION OF HEALTH SERVICE REGULATION

**Prior to adding an additional clinical site, a new form must be completed and submitted to our office for approval.
Form may be found at www.ncnar.org.**

School/Facility _____

Street _____

City _____ State _____ Zip Code _____ County _____

Area Code and Telephone Number _____

Program Coordinator's Name _____ E-Mail _____

Current Clinical Site with Address and Zip Code		Program Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Requested Clinical Site Approval (Name, Address, City, State, Zip)		For Program Number:
1.	Name of Facility _____ Address and Zip Code _____ Administrator _____	
2.	Name of Facility _____ Address and Zip Code _____ Administrator _____	
3.	Name of Facility _____ Address and Zip Code _____ Administrator _____	

Please use an additional form if more than three (3) sites are being requested for approval.

FOR OFFICE USE ONLY- DO NOT WRITE BELOW THIS LINE			
<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved	EXCEL LOG IN <input type="checkbox"/>	EXCEL LOG OUT <input type="checkbox"/>
Comments:			
Division of Health Service Regulation: Reviewed by: _____			
Signature	Date	Entered in dbase	